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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SIEW MEE GRISWOLD, AKA SHARON GRISWOLD, SIEW MEE WONG, and SIEW MEE NIL** **2936 Camino Capistrano, Unit D** **San Clemente, CA 92672** **Registered Nurse License No. 585235** Respondent.	Case No. 2011-473 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 10, 2001, the Board of Registered Nursing issued Registered Nurse License Number 585235 to Siew Mee Griswold, also known as Sharon Griswold, Siew Mee Wong, and Siew Mee Nil (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

REGULATORY PROVISIONS

8. Title 16, California Code of Regulations, section 1443, provides:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

9. Title 16, California Code of Regulations, section 1443.5, provides:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

WESTERN MEDICAL CENTER

11. Respondent was employed as a registered nurse in the Neonatal Intensive Care Unit (NICU) at Western Medical Center (WMC) in Santa Ana from October 1, 2001 through March

28, 2003, and was assigned to the night shift beginning at 7:00 p.m. and ending at 7:00 a.m. On March 24, 2003, Respondent was assigned to a 23-24 week premature female twin infant (BABY A) with an admitting diagnosis of extreme prematurity, respiratory distress and rule out sepsis. BABY A was born via C-section at 2032 hours on March 24, 2003 to a 19 year old mother with no prenatal care. Respondent's assignment was on a one-to-one basis, meaning that Respondent's only patient was BABY A, requiring Respondent to focus her entire attention on this patient.

12. After BABY A was delivered, she was transferred to the NICU and placed on high frequency ventilation. During the time that Respondent was assigned to caring for BABY A, several WMC staff members reported seeing Respondent asleep in the break room. The Respiratory Therapist at WMC observed Respondent sleeping and reported to Respondent that BABY A "did not look good." A nurse reported seeing Respondent go back and forth from her assigned baby's bedside to the middle break room. Another nurse at WMC observed Respondent "sound asleep in the break room for at least 20 minutes with the door closed and the lights out" at about 0130 hours on March 25, 2003 and had to shake Respondent in order to wake her up to inform her that BABY A's blood pressure was low. Another nurse who was caring for BABY A's twin sibling in the NICU reported that Respondent was not at BABY A's bedside when BABY A's blood pressure dropped. When Respondent returned, this nurse suggested to Respondent that she call the doctor but Respondent stated, "no, its okay" and "no, the baby's fixed."

13. Respondent denied sleeping but admitted to leaving BABY A's bedside to place eye drops in her eyes. Respondent did not have another nurse watch BABY A while she was away from her bedside. BABY A coded at approximately 0200 hours on March 25, 2003. Respondent was not at BABY A's bedside when the baby's alarm went off. The nurse caring for BABY A's twin sibling reported that at 0200 hours, Respondent was attempting to get a rush physician order for Dopamine from the pharmacy. Respondent was told by that nurse that they were resuscitating BABY A.

14. BABY A was pronounced dead at 0252 hours on March 25, 2003. Respondent admitted that she did not chart the care she provided to BABY A until after the baby died. In

BABY A's medical chart, Respondent documented a telephone physician's order for IV Dopamine 5mcg at 0215 hours on March 25, 2003, however, she documented administration of this medication to BABY A at 0200 hours on March 25, 2003. In her own written Incident Report, Respondent documented a conversation with the doctor wherein the doctor questioned Respondent about not informing her of the baby's dropping blood pressure. In her Incident Report, Respondent also admitted that she took a break around 0135 hours to take her anti acid reflux tablet.

15. Respondent was terminated from her employment at WMC on March 28, 2003 for "sleeping/appearance of sleeping in a direct patient care area."

FIRST CAUSE FOR DISCIPLINE

16. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her employment at WMC, Respondent was incompetent in that she failed to exercise the degree of learning, skill, care and experience ordinarily possessed by a competent registered nurse as evidenced by her failure to provide adequate supervision and care for her assigned patient, BABY A, as forth in paragraphs 11 through 15 above, which are incorporated herein as though set forth in full.

GARDEN GROVE HOSPITAL

17. Respondent was employed as a registered nurse by MGA Healthcare nurse registry and assigned to Garden Grove Hospital in Garden Grove. On May 31, 2007, Respondent was assigned a patient who had undergone an endoscopic exam. The patient complained of nausea and vomiting. Respondent checked the patient's Medication Administration Record and discovered that the patient had a prior order for IV Zofran.[1] There was no Zofran available in the patient's medication cart so she contacted the pharmacy. The pharmacy told Respondent that the order had been discontinued. Respondent was also told by the pharmacy that in order to re-

[1] Zofran, a brand name for ondansetron, is used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. Ondansetron is in a class of medications called 5-HT3 receptor antagonists. It works by blocking the action of serotonin, a natural substance that may cause nausea and vomiting. Ondansetron is a dangerous drug pursuant to Business and Professions Code section 4022.

activate the physician's order, it needed to be rewritten/reordered. Respondent then attempted to contact the doctor of record, however, the doctor was unavailable. Respondent left a message for the doctor regarding the need to renew the physician's order for Zofran. Without speaking to the doctor and without authorization, Respondent wrote the renewal order for Zofran herself.

18. Around the same time that Respondent wrote the renewal order for Zofran, a doctor who was covering for the patient's doctor of record, arrived at the unit and saw the order for renewal of Zofran. The doctor stated that he did not want the patient to receive the Zofran and instead, he wanted the patient to receive Benedryl IV. The doctor then wrote an order for IV Benedryl in the patient's chart. After Respondent learned that the doctor did not want the patient to receive Zofran, she drew a "squiggly line" through her written order for Zofran on the patient's chart. However, Respondent did not make an "error" note or initial the notation.

19. The Director of Med Surg at Garden Grove Hospital learned of the incident and conducted an investigation on the same day. During her interview, Respondent admitted that she wrote the order without speaking with the doctor. Respondent was admonished by the Director that writing physician's orders was the practice of medicine and outside the scope of her nursing practice. Respondent's response was "I do this all the time." Respondent was then asked to leave the hospital.

SECOND CAUSE FOR DISCIPLINE

20. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her shift at Garden Grove Hospital, Respondent was incompetent in that she failed to exercise the degree of learning, skill, care and experience ordinarily possessed by a competent registered nurse when she wrote a prescription for medication for her patient, as forth in paragraphs 17 through 19 above, which are incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 585235, issued to Siew Mee Griswold, also known as Sharon Griswold, Siew Mee Wong, and Siew Mee Nil.

2. Ordering Siew Mee Griswold to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/23/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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